Application for Kentucky Children's Health Insurance Program (KCHIP)

IF YOU NEED HELP WITH THIS FORM CALL OUR TOLL-FREE NUMBER 1-877-KCHIP-18.
FOR PEOPLE WITH HEARING PROBLEMS CALL 1-877-524-4719.

Mail completed application and documentation:
KCHIP
P.O. Box 1704
Louisville, KY 40201

1. List name of parent. If parent does not live in the home, name of responsible person.

Last Name of Parent/Responsible Person | First Name | Middle Initial

Street Address (Include Apartment/Lot Number) You can apply even if you don't have an address

City | State | Zip Code | County

Mailing Address, if different (Include Apartment/Lot Number)

City | State | Zip Code

Phone where you can be reached:

Home: _____

Work: _____

Other: _____

Whose phone is this? _____

2. Provide the following information on the children for whom you are applying for health coverage. (If you need more room, attach a separate sheet).

Last Name	First Name	Middle Initial	Sex	Race	Date of Birth	Social Security Number	Is this person a US Citizen? If no, attach INS documentation		Is this person pregnant? If yes, attach doctor's statement	
							YES	NO	YES	NO

3. Provide the following information for all other individuals living in the household with the children listed in Section 2.

Last Name	First Name	Middle Initial	Sex	Race	Date of Birth	Social Security Number	Is this person pregnant? If yes, attach doctor's statement		Relationship to the children. Example: Mother of Mary, Father of Bob, Stepmother of Mary, Stepfather of Bob, Sister of Bill, Brother of Bill, Not Related
							YES	NO	

4. Tell us about your family income. List only parents' and childrens' income, if any. (If you need more room, add a separate sheet of paper and attach to this application).
Be sure to include all sources of income (before taxes) such as wages, KTAP, disability, pension, child support, alimony, cash gifts, alien sponsor income, annuities, interest, dividends and other unearned income. If self-employed, attach your most recent federal tax form. **For wages, provide copies of your pay stubs for the last calendar month or a letter from your employer.** For unearned income such as Social Security, pensions, VA or RR retirement, provide your most recent award letter. If you are not sure what to send, call our toll-free number 1-877-524-4718 and we will help you.

Name of person(s) receiving money	If working, name and address of employer	Who provides money? Employer, program, person	Paid how often? Weekly, bi-weekly, twice a month, monthly, annually	Is a child (children) who earned income still in school? YES	NO	What amount is received before taxes and any deductions (Gross income)

5. Did anyone whose wages are listed in Section 4 pay someone to take care of a child and/or disabled adult living in your home while they work?
(If you attach proof of expense, we may be able to give you a deduction.)

Name of child or disabled adult	Age	Who do you pay and how much?

6. Does anyone applying have health insurance now that covers doctor's office visits and hospitalization?

Insurance Company or Employer	Policy Number	Policy Holder's Name	Policy Holder's SSN	Who is covered by this plan?

7. Did any child lose health insurance in the last six months? _____ Yes _____ No If yes, why? _____

8. Do you owe any medical bills for your children within the past 3 months? _____ Yes _____ No
If yes, what kind of bills (doctor, hospital, lab, etc.), how much and month(s) when services were received? _____
(We may be able to help you pay for unpaid medical bills if you are approved for KCHIP)

9. Did anyone help you fill out this application? _____ Yes _____ No If yes, list their agency, name and address. _____

Social Security Number (SSN)
If you are applying for KCHIP for a child, you are not required to provide your own Social Security Number (SSN), but we MUST have the child's SSN in order for the child to receive KCHIP. This policy is dictated by section 1137(a)(1) of ,the Social Security Act and the Medicaid regulations of 42 CFR 435.910. The Medicaid agency will use the SSN to verify your income, eligibility, and to determine the amount of KCHIP payments we will make on your behalf. It is possible that the Medicaid agency will also use the SSN to determine another person's right to Medicaid or to comply with Federal Law requiring that we release information from Medicaid records. The information may be matched with the records in other agencies, such as the Social Security Administration or the Internal Revenue Service. These matches may be done by computer or on an individual basis. If the applicant does not have an SSN number, this application will be processed while the family applies for a SSN or receives assistance in applying for a SSN.

Rights and Responsibilities
I agree to the release of personal and financial information from this application form and supporting documents to the state agencies or their contractors that run this program so that they can evaluate it and verify eligibility. I understand that the agencies that run the program will determine confidentiality of this information according to the federal laws, 42CFR 431.300 - 431.307.1, and any applicable federal and state laws and regulations. I understand that I must immediately tell the Department for Community Based Services (DCBS) agency about any changes in information on this form. I understand that I may be asked to provide additional information. I understand my eligibility will not be affected by my race, color, national origin, age, disability, sex, religious creed, or political beliefs except where this is restricted by law. I understand that this application is an application for KCHIP and is NOT a full Medicaid application. I understand that if I am not found eligible for KCHIP, I may be eligible for Medicaid benefits on some other basis and have a right to complete a full Medicaid application.

Signature _____ Date signed _____

I have the right to appeal any eligibility decisions made by DCBS. Information on this appeals process can be obtained from DCBS. I declare that all persons for whom application is made are US citizens or are admitted under an approved alien status. I certify, under penalty of perjury, the information, including citizenship or alien status, provided by me in this statement is correct and true to the best of my knowledge and give my consent to make any necessary contacts to verify my statements. I understand that anyone who gives false information or conceals information in order to receive or to continue to receive Medicaid benefits; or let someone else use your Medicaid card; or abuses Medicaid benefits is subject to criminal action under federal law, state law or both. I also understand that I may be liable for repaying in cash the value of the benefits received.